

Uncompensated Care Pool:

Frequently Asked Questions (FAQs)

Regulations, Eligibility, and Billing

September 6, 2005



Stephen McCabe, Acting Commissioner

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i. DHCFP CONTACT INFORMATION

For providers:

For questions about filling out an MBR:

Contact 888-665-9993, the central number of the MassHealth Enrollment Centers, as you do today.

For questions about how to use the common virtual gateway application, or problems with the virtual gateway:

Contact the Virtual Gateway Help Desk at: 800-421-0938.

For UCP policy questions:

UCP policy and business questions will continue to be answered by the help line at the Division of Health Care Finance and Policy: 617-988-3222.

For problems with the existing Free Care application software:

Problems with the DHCFP Free Care application software can be directed to each facility's provider liaison. The main number is: 800-542-7648.

For Patients:

For questions about a UCP eligibility determination, or about which services are eligible for payment from UCP:

Questions should be directed to the UCP help line at: 877-910-2100.

To file a grievance regarding the UCP:

Questions about filing a grievance should be directed to the UCP help line at: 877-910-2100.

To file a grievance, the patient should send a letter to:

Division of Health Care Finance and Policy
Attn: UCP Grievance
Two Boylston Street
Boston, MA 02116

The letter should include, at a minimum, the patient's **name and address**. If possible, it should also include information about the situation, the reason for the grievance, the **provider's name** (if a provider is involved), etc. The more information that the patient gives, the better. It is very important to include the provider's name if a provider is involved.

1. APPLICATION QUESTIONS

NEW

UCP and the Age 65 and Older Population

Virtual Gateway applications and paper S-MBRs now determine both MassHealth and UCP eligibility for the Community Elder population. By using this application, a patient aged 65 or older may receive a MassHealth or UCP determination.

Once providers are trained to use the new Virtual Gateway application for seniors, Electronic Free Care applications may no longer be used for this population. Electronic Free Care Applications may only be used for confidential applications, and for Medical Hardship applications.

UCP Eligibility and the Asset Test for Applications Over 65

UCP determinations do not require an asset test (with the exception of Medical Hardship applications). However, to apply for the UCP, all patients must first apply for MassHealth. The application for patients aged 65 and older requires an asset test to determine eligibility. The information provided in the asset portion of the MassHealth application is used to determine MassHealth eligibility but does not factor into the UCP determination.

1.1 Basic Overview

1.1.1 Basic Application process as of 10/1/04:

Beginning 10/1/04, providers will be transitioning to a unified application through the Virtual Gateway system. During the transition there will be three methods of determining Low Income Patient (UCP) status:

1. Those providers with access to the Virtual Gateway (VG) should use the gateway, but if they are within their 60-day transition period they may also continue to use the electronic Free Care application.
2. Providers, whether or not they have access to the VG, may use the paper MBR application and send it to the MassHealth CPU. These applications will determine if an individual is a Low Income Patient as well as determine their eligibility for MassHealth after 10/1/04. Determinations for these applications will be accessible through REVS.
3. Providers without access to the VG may continue to use the electronic Free Care application to determine Low Income Patient status only. These applications will not be determined through MA-21 and eligibility determinations will not be accessible through REVS.

After 10/1/04, hospitals and CHCs will continue to process applications for individuals aged 65 or older and for those applying for medical hardship. These applications will be submitted to DHCFP using the electronic Free Care application. Because these types of applications are done by the facilities themselves, the Low Income Patient status of these individuals will not be visible on REVS.

1.1.2 Applicant's Eligibility Period:

Low Income Patient applications processed with the existing Free Care application software will continue to be valid for one year.

Applicants determined through the MassHealth system will be considered Low Income Patients for one year; however, these Low Income Patients must comply with the MassHealth re-determination procedures and documentation requirements. Re-determinations are possible during the year long period for which the person has been determined a Low Income Patient.

1.1.3 MBR Requirement:

Providers are not required to generate an MBR for applicants if the provider is not on the Virtual Gateway and is using the electronic Free Care application. As of 10/1/04 the MBR can be used as an application for both UCP and MassHealth. Using the MBR will allow patient data to be processed through the MA-21 system that links to REVS. This will allow an applicant's determination to be state-wide and viewable on REVS upon determination.

1.1.4 Applications at Home:

Providers can hand out or send a paper MBR to the patient and instruct the patient to return the completed form directly to the MassHealth CPU. Alternately, providers may direct applicants to return the application to the provider and the provider may then send the application to the CPU. The provider should not, however, use the application to fill out an application via the Virtual Gateway using the information on the form.

1.1.5 Applications with No Social Security Number (SSN):

Individuals may still apply for MassHealth even without an SSN. These individuals may still be eligible for certain MassHealth programs, and/or be determined Low Income Patients.

1.1.6 Refusal to apply for MassHealth:

Until a facility is transitioned onto the Virtual Gateway, an individual may still apply solely for Low Income Patient status using the electronic Free Care application. However, under regulation 114.6 CMR 12.00, applicants must first be screened by the provider for MassHealth eligibility. If a provider has been transitioned to the Virtual Gateway all applications will be screened for MassHealth eligibility before Low Income Patient status is determined. Individuals may not choose to apply solely for Low Income Status once a provider is on the Virtual Gateway.

1.1.7 Medicare Patients under age 65:

These patients should utilize the MBR or Virtual Gateway application (or the FC application before the provider is transitioned onto the Virtual Gateway). Patients aged 65 and older, regardless of Medicare coverage, should use the electronic FC application.

1.1.8 UCP and the Age 65 and Older Population

Virtual Gateway applications and paper S-MBRs now determine both MassHealth and UCP eligibility for the Community Elder population. By using this application, a patient aged 65 or older may receive a MassHealth or UCP determination.

Once providers are trained to use the new Virtual Gateway application for seniors, Electronic Free Care applications may no longer be used for this population. Electronic Free Care Applications may only be used for confidential applications, and for Medical Hardship applications.

1.1.9 UCP Eligibility and the Asset Test for Applications Over 65

UCP determinations do not require an asset test (with the exception of Medical Hardship applications). However, to apply for the UCP, all patients must first apply for MassHealth. The application for patients aged 65 and older requires an asset test to determine eligibility. The information provided in the asset portion of the MassHealth application is used to determine MassHealth eligibility but does not factor into the UCP determination.

1.1.10 Application Approval Letters:

The regulation stipulates that patients must be notified of the availability of the UCP through notices on patient bills and collection actions. If a facility uses the MassHealth process for its Low Income Patient determinations, a notice will be generated detailing the patient's status. If the facility uses the FC application software, the provider is still required to send its own determination letter.

1.1.11 Confidential UCP applications:

For minors that require confidentiality, Low Income Patient status can continue to be determined using the FC desktop application. Providers must collect documentation of the patient's request for confidentiality and keep this documentation (such as a signed affidavit or letter from the patient) in the patient's file with the UCP application.

If a minor requests confidential services and is already known to the MassHealth system (e.g. the family includes MassHealth members, or the family had MassHealth eligibility within the last year), MassHealth has processes for ensuring that the patient can receive confidential services without the family being notified. The MassHealth Enrollment Center should be contacted; a separate FC application is not necessary.

In the case of minors who are covered by a private insurance policy but require confidential services, it should be noted that, in these cases, using the MassHealth system does not ensure complete confidentiality. These patients should continue to use the electronic FC application to ensure that claims are processed confidentially.

Providers who have transitioned onto the Virtual Gateway can continue to use the electronic FC application tool for this population to ensure that confidential services can be provided.

1.1.12 Applications for Deceased Persons:

For facilities not yet transitioned onto the Virtual Gateway, Free Care electronic applications for deceased patients can still be submitted.

Applications for deceased applicants using the MassHealth process should be submitted using the paper MBR (deceased applicants over 65 should utilize the Universal Application for Medical Benefits for persons aged 65 and over). The submission of an ERD form authorizes the application to be made on behalf of a deceased person. An application using the paper MBR will be determined for MassHealth and Low Income Patient status.

1.2 Required Income and Residency Documentation and Verifications

1.2.1 Residency Verification Process:

Beginning 10/1/04, residency verification for the UCP will be done through MA-21 for all UCP applications made using the Virtual Gateway or paper MBR. Low Income Patients must be Massachusetts residents, but, in accordance with the MassHealth application process, residency will be established through letters to applicants sent by MA-21. If a letter is returned for an inaccurate address, it will be assumed the applicant is a non-resident and MA-21 will terminate the applicant's Low Income Patient status.

For facilities that continue to use the electronic Free Care application, the current documentation procedures remain the same, and patients must supply the required residency and income documentation.

1.2.2 Residency Verification Process—Homeless:

The MBR and Virtual Gateway common intake forms include an indicator for homelessness that enables complete processing of the application and prevents homeless MassHealth members or Low Income Patients from being terminated due to a lack of residence.

1.2.3 Storage of Applications and Documentation:

All collected MassHealth MBRs and supporting documentation, regardless of whether they are for MassHealth or Low Income Patient status, will be handled in the manner in which providers process documentation for MassHealth purposes.

Applications for those aged 65 and older and medical hardship applications providers will continue to use the existing application process and keep necessary documentation at their sites.

1.2.4 Pending FC Application—REVS as Documentation for Income and Residence:

If an application at a specific facility is awaiting documentation from the patient, but then the patient's Low Income Patient (UCP) status becomes visible in REVS, the REVS message cannot be used as "documentation" for that pending application. The REVS print-out does not provide sufficient information about the applicant's residence and income to qualify as documentation.

Until the patient completes the pending application, the determination shown in REVS should be used as the valid determination. If the patient completes the pending facility-specific application (with the correct documentation), the provider may use that determination or the REVS determination for billing purposes (*see the related Eligibility Question regarding different determinations*). Once providers are transitioned completely onto the Virtual Gateway, the MassHealth process will be the only eligibility determination system for UCP / MassHealth.

1.3 Applications for Individuals with Current MassHealth Eligibility:

EAEDC: EAEDC provides coverage for emergency physician services at a hospital, all services provided by a CHC, and certain other services. Those medically necessary services not covered by MassHealth for this population may be billed to the UCP. Providers must make every reasonable effort to have EAEDC patients enroll in MassHealth and document all such efforts. Most EAEDC patients are eligible for MassHealth Basic and may enroll in MassHealth without submitting an MBR / Virtual Gateway common intake application. These patients should be instructed to call the Health Benefits Advisor at 800-841-2900 to enroll.

Healthy Start: Providers must check REVS to determine patient status. Individuals approved for Healthy Start after July 1, 2004 will be listed on REVS under the coverage type: LMTD HLTHY STRT. Eligible women approved for Healthy Start before July 1, 2004, will not have their Healthy Start eligibility listed in REVS. If REVS shows LMTD HLTHY STRT, providers may bill the UCP for Eligible Services provided that they are not covered by either MassHealth Limited or MassHealth Healthy Start.

CenterCare: CenterCare enrollees use a CHC as their primary care provider. Since CenterCare is not a MassHealth program they will not be listed on REVS. To establish the patients' status, the provider must complete the MassHealth application process with the patient.

CMSP: Providers must check REVS to determine patient status. Individuals approved for CMSP after July 1, 2004 will be listed in REVS under one of two coverage types: CMSP, or LMTD CMSP. Providers may bill the UCP for services not covered by any other insurance or program for individuals with MassHealth Limited and CMSP who are also Low Income Patients. For those with only a CMSP coverage type, the provider must check the patient's CMSP card to determine whether the provider may bill the pool for services provided to the patient not covered

by the patient's other insurance or benefits. These cards show the patient's FPL; only providers whose patients are under 400% FPL may receive UCP payment for services not covered by other insurance or programs. If a patient is at 400% FPL or greater, REVS will display a message showing the UCP may not be billed. However, if an applicant is between 200-400% of FPL, the applicant may receive Partial Low Income Patient status. If the family income can be determined, the provider must calculate the deductible using the formula found at 114.6 CMR 12.03 as shown at Sec. 1.7.4 of this document: Otherwise they may calculate a deductible as though the family has an income equal to 201% FPL. For a chart and specific deductible amounts see 4.5.2.

1.4 Condensed UCP Applications

1.4.1 Condensed Applications:

Condensed applications will continue to be used.

1.4.2 Condensed Applications for Patients Who Go to Another Facility:

For patients not listed on REVS but who receive services at more than one facility, a condensed application is needed to demonstrate Low Income Patient status at other facilities that have not yet transitioned onto the Virtual Gateway.

A condensed application is no longer necessary to ensure that providers are able to bill for services rendered to Low Income Patients not covered through MassHealth. MassHealth patients are not required to fill out the condensed form.

1.5 Virtual Gateway

1.5.1 Virtual Gateway Application Pending:

If a patient has a VG application submitted, but no determination has been made and this patient presents for services at another facility, this patient's status is "pending." S/he should not submit another application. The provider can contact the original provider where the application was completed to inquire about its status. The provider can also contact the MEC at 888-665-9993 to check on the status of an application.

1.6 Information on MassHealth Processes

1.6.1 MassHealth Income Affidavits:

As of 10/1/04, Low Income Patient determinations through MA-21 will be completed according to the MassHealth rules of necessary documentation.

For applicants with income, MassHealth documentation is required for all eligibility determinations. For income documentation, MassHealth considers affidavits “reliable evidence” only as a last resort when no other documentation is available. If an applicant claims no income, then under MassHealth rules, no documentation is required, and the application will be processed as it is currently for MassHealth applicants with no income.

1.6.2 MassHealth Income Calculations for Seasonal Workers (Fishermen, Landscapers):

For these applicants, a filed US tax return is the best form of documentation because it shows annual income. If a seasonal worker provides pay stubs, the income calculated will be higher than the worker’s actual income. A letter from the employer is also valid and is considered appropriate documentation of variable income.

1.6.3 Residency Verification

Beginning 10/1/04, residency verification for the UCP will be done through MA-21 for all Low Income Patient applications made using the Virtual Gateway or paper MBR. Low income patients must be Massachusetts residents. In accordance with the MassHealth application process, residency will be established through letters to applicants sent by MA-21. If a letter is returned for an inaccurate address, MA-21 will rescind that person’s Low Income Patient status.

Facilities that continue to use the electronic Free Care application after 10/1/04 (before they transition to the Virtual Gateway) must collect Massachusetts residency documentation from all individuals seeking Low Income Patient status determinations, as they do currently.

1.7 Eligibility Re-Determinations—UCP and MassHealth Processes

1.7.1 New Income Documentation, Partial UCP Deductible:

Whenever a patient reports a change in circumstances, such as a change in family size or income, a re-determination can be completed using the MassHealth application process or the electronic FC desktop software for providers not yet transitioned onto the Virtual Gateway. New determinations, including new Partial UCP deductible amounts are possible. If the patient has bills being applied to a deductible from a previous determination, they can be applied toward the new deductible.

1.7.2 UCP Re-Determination Using the Electronic FC Application and Eligibility Period:

A re-determination due to a change in financial circumstances or family size does not trigger a new eligibility period. An eligibility re-determination based on new information that uses the electronic FC desktop software should be completed using the same eligibility dates as the initial application. For example, an applicant approved for Partial Low Income Patient status in May who submits new income documentation in October should retain the eligibility period of May 2004 - May 2005.

A non-resident who was determined to be a Low Income Patient prior to 10/1/04 can also have a re-determination based on new documentation within the eligibility period. This re-determination does not start a new eligibility period.

1.7.3 Eligibility Re-determination through the MassHealth Process (VG or Paper MBR) and Eligibility Period:

A re-determination due to a change in financial circumstances or family size does not trigger a new eligibility period. If the new information (new pay stubs, for example) results in no change to the eligibility category, then the eligibility dates remain the same and the patient will not receive a MassHealth notice. If the MassHealth / UCP status is upgraded, downgraded, or terminated, then the patient receives a MassHealth notice and the “benefit effective date” changes. However, this does not mean that the patient receives a “new” one-year eligibility period. The timing of the annual review does not change because the “review date” is based on the date of initial application.

Low Income Patients who have had their status determined through the MassHealth process should follow the MassHealth processes and procedures for submitting changes. They are required to contact MassHealth regarding any changes in income, family size, employment, disability status, health insurance, and address within 10 days or as soon as possible.

1.7.4 Partial UCP Deductible Calculation:

The Partial UCP deductible is calculated as follows:

[Gross family income – (200% FPL)] x 40% = annual deductible

Example: for a family of 2 at 300% FPL (using the MassHealth income guidelines)

$\$37,476 - (\$24,984) \times 40\% = \$4,996.80$

2. ELIGIBILITY QUESTIONS

NEW

Wrap-around Coverage for the Age 65 and Older Population

Individuals found eligible for the MassHealth senior programs may also have UCP eligibility for some services not covered by MassHealth.

This is subject to any annual revision of 114.6 CMR 12.00.

If a patient is dually eligible for both Medicare and MassHealth, the UCP will always be the payer of last resort and will only pay for services not covered by either program.

UCP Eligibility and the Asset Test for Applications Over 65

UCP determinations do not require an asset test (with the exception of Medical Hardship applications). However, to apply for the UCP, all patients must first apply for MassHealth. The application for patients aged 65 and older requires an asset test to determine eligibility. The information provided in the asset portion of the MassHealth application is used to determine MassHealth eligibility but does not factor into the UCP determination.

2.1 UCP Eligibility Determination after 10/1/04 (under 114.6 CMR 12.00): The Basics

2.1.1 Overview of Low Income Patient Determination:

Pursuant to 114.6 CMR 12.00, effective 10/1/04, patients may no longer apply directly for Low Income Patient (UCP) status; they must first apply for MassHealth through the MassHealth application process. Individuals who are ineligible for MassHealth are screened for Low Income Patient status, and, if so determined, are notified by MassHealth. Patients who are Low Income Patients can be found in the REVS system.

There are some exceptions to this requirement. Hospitals and community health centers must continue to submit applications to DHCFP for Low Income Patients using the existing electronic desktop Free Care software application for the following groups:

- Individuals aged 65 and older
- Individuals applying for Medical Hardship.

In addition, providers who are not yet using the Virtual Gateway common application intake tool may continue to use the existing Free Care application software for all Low Income Patient

determinations until they have transitioned onto the Virtual Gateway. Once a provider has completed training and begun to submit applications to MassHealth through the VG, they have a 60-day transition period at the end of which all applications for Low Income Patient status, except those listed above, must be submitted through the MassHealth application process (using the VG or a paper MBR). The Division will send a letter to each provider informing them of the start date of their 60-day transition period, and the date by which they must have converted to using the MassHealth application process.

Please see the document's *Application Questions* section, Section 1, for further information about Low Income Patient applications.

2.1.2 Providing Notification of MassHealth/UCP Determinations:

Before a patient can submit an application through the virtual gateway (VG), he/she must sign a permission to share information (PSI) form that allows the provider to process the application. Both the patient and the provider named on the PSI form will receive letters from MassHealth notifying them of the outcome of the determination. If the applicant uses the paper MBR, the provider will only get a letter if the patient fills out a PSI and requests that a letter be sent to the provider. PSIs are required for the Virtual Gateway common intake application. PSIs are not required for paper MBRs, but patients have the option to fill them out.

2.1.3 Length of Eligibility Period under New Regulations:

Pursuant to regulations effective 10/1/04, the Low Income Patient status is maintained for a period of one year, beginning on the start date as determined by MassHealth (i.e., 10 days prior to the date the MassHealth application is received). In addition, a provider may bill the UCP and receive payment for services rendered up to 6 months before the date of determination.

2.1.4 Length of Eligibility Period under Old Regulations, or with Existing Free Care Software:

Until the MassHealth application process (Virtual Gateway or paper MBR) is used for eligibility determinations, Low Income Patient status determined through the existing Free Care software will remain facility-specific. The eligibility period will continue to be one year.

Providers using the "old" Free Care application after 10/1/04 must use the 6 month retroactivity limitation. If a patient had Low Income Patient (UCP) status prior to 10/1/04, determined through the "old" Free Care application, then that provider can bill for dates of service from up to one year prior to the eligibility date. In short, any UCP application submitted on or after 10/1/04 uses the 6 month retroactive billing period; any UCP application submitted before 10/1/04 uses the one year retroactive billing period.

2.1.5 Facility Specific Eligibility vs. Statewide Eligibility

All eligibility determinations completed through the MassHealth process (Virtual Gateway or paper MBR) after 10/1/04 will be considered state-wide determinations, not facility-specific

determinations as was the case through the old system. Low Income Patient and MassHealth determinations will be accessible through REVS, and participating providers throughout the state will be able to verify a patients' status through REVS.

REVS will always show the richest aid category for an individual. If a patient is eligible for MassHealth, a MassHealth message will be visible; if the patient is only a Low Income Patient, then only a UCP message will be visible [i.e., Coverage Type: Full Free Care or Partial Free Care]. Once a patient is determined eligible for MassHealth, providers can bill the UCP for Eligible Services provided to Low Income Patients that are not covered by any other insurance or benefit without any additional determinations or applications.

Low Income Patient determinations made through the "old" Free Care application process will continue to be facility-specific. These Low Income Patient determinations will not be accessible through REVS.

2.1.6 Portability and Proof of Eligibility for UCP Determined through the MassHealth Application Process (Virtual Gateway or paper MBR):

If a patient's Low Income Patient status is determined through the Virtual Gateway or the paper MBR, it is portable—that is, it is applicable at all acute care hospitals and community health centers in Massachusetts that participate in the UCP. Any provider, even if they are not yet connected to the Virtual Gateway, can go into REVS and check patient status.

2.1.7 Low Income Patient (UCP) Status and REVS:

Low Income Patient status can be checked using REVS after 10/1/2004 if the patient has applied using the MassHealth application process (Virtual Gateway or paper MBR). REVS will always show the richest aid category for an individual. If a patient is eligible for MassHealth, a MassHealth message will be visible; if the patient is only a Low Income Patient, only a UCP message will be visible. The provider may bill the pool for medically necessary Eligible Services rendered to MassHealth patient that are not covered by any other insurance or benefit.

2.1.8 Documenting a Patient's UCP determination:

If the patient has applied for UCP through the MassHealth application process and appears on REVS, the provider can keep a REVS print out documenting MassHealth/Low Income Patient status on the date of service in question. No condensed application is necessary.

2.1.9 When to use a Condensed Application:

Until a provider begins using the MassHealth application process (Virtual Gateway or paper MBR) for eligibility determinations, Low Income Patient status determined through the existing Free Care software will remain facility-specific.

- If a patient is found to be a Low Income Patient at a facility using the existing **Free Care software**, and then visits another facility, the new provider must fill out a condensed application to determine that patient's eligibility at the new facility.
- However, if the new **provider has access to the Virtual Gateway**, that provider should use the MassHealth application process to complete a new application for the patient.

2.1.10 Documenting Fulfillment of a Partial UCP Deductible:

Without proof that an individual has met his/her Partial UCP deductible, claims for services cannot be written off to the Uncompensated Care Pool. Providers are responsible for tracking bills if a patient has no other family members and uses only one facility. Patients are responsible for tracking their own bills if more than one member of the family is using UCP services, or if patients are using more than one medical facility to receive their care. Providers can assist patients by contacting other hospitals and/or CHCs to try to get documentation of a met deductible.

2.1.11 UCP Eligibility and the Asset Test for Applications Over 65

UCP determinations do not require an asset test (with the exception of Medical Hardship applications). However, to apply for the UCP, all patients must first apply for MassHealth. The application for patients aged 65 and older requires an asset test to determine eligibility. The information provided in the asset portion of the MassHealth application is used to determine MassHealth eligibility but does not factor into the UCP determination.

2.1.12 Critical Access Services:

Critical Access Services are defined in the regulations at 114.6 CMR 12.03(2)(b).

Time of Day Clarification

Time of day is not a factor in the determination of critical access services. If urgent care, as defined in the regulation, is needed, it may be provided at a hospital.

Can providers bill a Patient who would like to continue to see their current doctor at a hospital instead of receiving primary care at a CHC?

Providers may not bill Low Income Patients except for MassHealth and UCP co-pays and deductibles.

2.2 Elimination of one-time UCP Eligibility for Charges <\$500

As of 10/1/04, there are no longer any one-time UCP payments for charges <\$500. This provision has been eliminated from the UCP regulations.

2.3 UCP Eligibility and Non-Residents

As of 10/1/04, non-residents of Massachusetts cannot be determined to be Low Income Patients. However, non-residents who are currently Low Income Patients (determined prior to 10/1/04) may receive services during their eligibility period at the facility where they applied. They may not receive services at another facility, since their UCP determination is facility-specific.

A non-resident who was approved for UCP prior to 10/1/04 can also have a re-determination based on new documentation within the eligibility period. This re-determination does not start a new eligibility period.

2.4 Services Billable to UCP (Wrap-around)

2.4.1 UCP Billable Services for MassHealth Members:

Services not covered by MassHealth, but that are UCP “eligible services,” may be billed to the UCP. Some exceptions are as follows:

- MassHealth co-pays with dates of service on or after 10/1/04 may no longer be billed to the UCP.
- MassHealth deductibles with dates of service on or after 10/1/04 may no longer be billed to the UCP.

2.4.2 MassHealth PCCs and UCP Billable Services

Providers may not submit claims to the UCP for MassHealth members who receive services at a PCC that is not their designated PCC.

2.4.3 Eligibility Documentation for Patients with MassHealth:

For UCP wrap-around, the provider can keep a REVS print out documenting MassHealth eligibility on the date of service in question. No condensed application is necessary.

2.4.4 CommonHealth Members and Low Income Patient status:

All patients who qualify for MassHealth are Low Income Patients. Therefore, providers may bill the UCP for patients enrolled in CommonHealth for Eligible Services provided to said patients that are not covered by CommonHealth.

2.4.5 Resident Students and UCP Wrap-around:

Massachusetts resident students are required to have student health insurance.

Patients may apply to be determined Low Income Patients, and providers may bill the UCP for services not covered by MassHealth, other insurance or benefits.

2.4.6 UCP Wrap-around the Age 65 and Older Population

Individuals found eligible for the MassHealth senior programs may also have UCP eligibility for some services not covered by MassHealth.

This is subject to any annual revision of 114.6 CMR 12.00.

If a patient is dually eligible for both Medicare and MassHealth, the UCP will always be the payer of last resort and will only pay for services not covered by either program.

2.5 When the UCP Determination as shown on REVS Conflicts with Facility-Based Eligibility:

2.5.1 Discrepancies between UCP Determinations Made through MassHealth and Determinations Made by a Provider Using the Existing Free Care Eligibility Software:

2.5.1.1 Overview

Once a determination has been made through the MA-21 system and is visible on REVS, the determination is to be considered valid even if the provider is not on the Virtual Gateway. If the patient has been determined through MA-21 at a different provider location or through a MassHealth re-determination process, *the determination made through MA-21 is the valid determination*. Exceptions to this rule are explained below. All providers should check REVS first for any patient determination information.

2.5.1.2 Differing deductible amounts for Partial UCP determinations:

During this transition period, the Division will allow some provider discretion in the matter of Partial Free Care (FC) deductibles. If a provider has a Low Income Patient with a deductible but REVS indicates a different deductible amount, the provider may choose to apply the lower deductible.

For example, if a patient's deductible from the provider's FC determination is lower than the one displayed by REVS, the provider can use the FC determination until the patient's one year of eligibility expires. The opposite situation may also occur, in which the deductible calculated by the provider is actually higher than the one that shows up on REVS. Again, the provider has a choice of which deductible it wants to use--the one displayed by REVS or the higher one in its FC database.

2.5.2 What if a Patient Has a Full UCP determination at a Provider but Shows up on REVS with a Partial UCP Determination?

This is a similar situation to a patient who has one deductible amount based on a Low Income Patient determination made by a provider, and a different deductible amount in REVS. As in that

situation, the provider can continue to treat that patient as a Full UCP patient until that patient's one year of eligibility expires. However, if that patient goes to another facility (where s/he does not have a UCP application), s/he will be treated as a Partial UCP patient as shown in REVS.

2.6 Special Circumstances

2.6.1 Low Income Patient Status during a Disability Determination Pending Period:

Individuals who have completed a DDU (Disability Determination Unit) supplement and require a disability determination will be considered Low Income Patients during this "pending period" if they are income eligible. Once a determination has been made, the applicant will convert to another MassHealth category on REVS if the applicant's disability affords them MassHealth coverage.

2.6.2 UCP and Eligibility for EAEDC, CenterCare, Healthy Start, or CMSP:

EAEDC: EAEDC provides coverage for emergency physician services at a hospital, all services provided by a CHC, and certain other services. Those medically necessary services not covered by MassHealth for this population may be billed to the UCP. Providers must make every reasonable effort to have EAEDC patients enroll in MassHealth and document all such efforts. Most EAEDC patients are eligible for MassHealth Basic and may enroll in MassHealth without submitting an MBR / Virtual Gateway common intake application. These patients should be instructed to call the Health Benefits Advisor at 800-841-2900 to enroll.

Healthy Start: Providers must check REVS to determine patient status. Individuals approved for Healthy Start after July 1, 2004 will be listed on REVS under the coverage type: LMTD HLTHY STRT. Eligible women approved for Healthy Start before July 1, 2004 will not have their Healthy Start eligibility listed in REVS. If REVS shows LMTD HLTHY STRT, providers may bill the UCP for Eligible Services provided that they are not covered by either MassHealth Limited or MassHealth Healthy Start.

CenterCare: CenterCare enrollees use a CHC as their primary care provider. Since CenterCare is not a MassHealth program they will not be listed on REVS. To determine eligibility, the provider must complete the MassHealth application process with the patient.

CMSP: Providers must check REVS to determine patient status. Individuals approved for CMSP after July 1, 2004 will be listed in REVS under one of two coverage types: CMSP, or LMTD CMSP. Providers may bill the UCP for services not covered by any other insurance or program for individuals with MassHealth Limited and CMSP who are also Low Income Patients. For those with just a CMSP coverage type, the provider must check the patient's CMSP card to determine whether the provider may bill the pool for services provided to the patient not covered by the patient's other insurance or benefits. These cards show the patient's FPL; only providers whose patients are under 400% FPL may receive UCP reimbursement for services not covered by other insurance or programs. If a patient is at 400% FPL or greater, REVS will display a message showing the UCP may not be billed. However, if an applicant is between 200-400% of

FPL, the applicant may receive Partial Low Income Patient status. If the family income can be determined, the provider must calculate the deductible using the formula shown at Sec. 1.7.4 of this document; otherwise they may calculate a deductible as though the family has an income equal to 201% FPL. For a chart and specific deductible amounts see **4.5.2**.

2.6.3 If a REVS Message says the Patient is Eligible for “Mental Health Services only; not Eligible for MassHealth,” can providers bill the UCP for non-Mental Health Services?

No, Low Income Patient status is not implied by a patient’s eligibility in these programs. REVS contains patient eligibility information about several other programs besides MassHealth, such as Senior Care Options, DMH programs, and pharmacy programs. This patient is in the REVS system due to eligibility in a DMH (Department of Mental Health) program and does not have MassHealth eligibility.

To determine eligibility for MassHealth / Low Income Patient status, the provider would have to do a Virtual Gateway application or an electronic Free Care application (if not on the Virtual Gateway yet).

2.6.4 If a patient shows up as Full UCP today, but a date of service check from ten days ago (or anytime within the past six months) shows up as Partial UCP, what does the provider use as the patient’s status?

Providers should use the most recent determination shown on REVS to determine the patient’s status. If a patient goes from Partial UCP to Full UCP, the provider may bill the UCP for any unpaid deductible amount.

2.7 UCP Eligibility Re-determination Process

2.7.1 Termination from UCP:

If a patient does not respond to the annual review process at MassHealth, and is consequently terminated from MassHealth, they cannot be determined a Low Income Patient, nor will they “default” into the UCP. Patients applying for the UCP must first be screened and/or enrolled in MassHealth prior to applying for UCP. If the patient completes the required information, the patient can be appropriately determined for MassHealth and UCP.

Low Income Patients whose eligibility is determined through the MassHealth application process (MBR or Virtual Gateway) are subject to the review procedures of MassHealth. These patients must comply with the review process to retain their Low Income Patient status.

2.7.2 MassHealth Enrollees Not Covered by MassHealth for Failure to Pay Premiums:

If a patient is processed and determined ineligible for MassHealth because s/he has failed to pay his/her MassHealth premium the patient will be screened for determination as a Low Income

Patient. If determined to be a Low Income Patient, REVS will indicate his/her status as a Full UCP or Partial UCP patient.

2.7.3 Patients Choosing not to “Accept” their MassHealth Eligibility and Choosing Uncompensated Care instead:

If a patient with MassHealth eligibility voluntarily withdraws from MassHealth, then s/he cannot be determined a Low Income Patient. UCP is not a “default” category that can be accessed by choosing not to be a MassHealth member. If a patient contacts MassHealth and asks to be voluntarily withdrawn from their program, s/he will not be found to be a Low Income Patient but will have his/her Low Income Patient status revoked.

2.8 Pharmacy Co-pays

2.8.1 CHC and Pharmacy Co-pays

CHCs may collect a co-pay to cover reasonable remaining pharmacy costs, but are given the flexibility to create their own co-pay structure. However, the cumulative revenue from all patient co-pays is not to exceed 25% of the aggregate Actual Acquisition Cost (AAC) of the drugs and un-reimbursed reasonable dispensing costs exceeding the \$7.50 dispensing fee.

2.8.2 Pharmacy Co-pays and Partial UCP deductibles:

Pharmacy co-pays cannot be counted towards a partial deductible. However, any additional amount owed by the patient based on the sliding scale cost of the prescription may be counted toward the patient’s deductible.

2.8.3 Partial UCP Patient Contribution for Prescriptions at a CHC:

A Partial-UCP patient must contribute a portion of the cost of their prescription based on the appropriate income determinate sliding scale percentage in addition to the co-pay the CHC may seek pursuant to 114.6 CMR 11.08(3)(a)(3)(b). For example: if a patient is required to contribute 20% of the bill, then the patient would have to pay: **20%(75% AAC + \$7.50)**. This portion of the patient contribution may count toward their deductible. Patients *are not* required to pay a separate fee for a CHC visit if there was no physician visit.

If a CHC assesses pharmacy co-pays pursuant to 114.6 CMR 11.08(3)(a)(3)(b), those pharmacy co-pays do not count towards a patient’s partial UCP deductible. However, the patient’s sliding scale contribution for the prescription counts toward the patient’s partial UCP deductible.

See also: **5.6.3, 5.6.4**

3. ELIGIBLE SERVICES

NEW

3.1 UCP Eligible Services: The Basics

3.1.1 Overview of Eligible Services:

Providers are allowed to bill the UCP for medically necessary services provided to Low Income Patients as defined in 114.6 CMR 12.03.

3.1.2 Medically Necessary Service:

A medically necessary service is defined as follows: A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity.

Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall not include: non-medical services, such as social, educational, and vocational services; cosmetic surgery; canceled or missed appointments; telephone conversations and consultations; court testimony; research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-surgery hormone therapy; and the provision of whole blood; except the administrative and processing costs associated with the provision of blood and its derivatives.

3.2 Critical Access Services Provision—Billing, Eligibility, etc.

3.2.1 Critical Access Services:

Critical Access Services are defined in the regulations at 114.6 CMR 12.03(2)(b).

Time of Day Clarification

Time of day is not a factor in the determination of critical access services. If urgent care, as defined in the regulation, is needed, it may be provided at a hospital.

Can providers bill a Patient who would like to continue to see their current doctor at a hospital instead of receiving primary care at a CHC?

Providers may not bill Low Income Patients except for MassHealth and UCP co-pays and deductibles.

3.2.2 Non-Eligible Services Due to Critical Access Restrictions:

UCP Providers may not bill Low Income Patients (114.6 CMR 12.08 (3)). See Billing Section.

3.2.3 Outpatient Psychiatric Treatment:

Psychiatric treatment by a specialist is a Critical Access Service.

3.2.4 Visits on a Hospital Campus to Obtain Ancillary Services (Radiology, Laboratory):

These are Eligible Services and therefore may be billed to the UCP.

3.3 Specific Services

3.3.1 Family Planning or Contraceptive Services:

Family planning services are only billable to the UCP if they are medically necessary, Eligible Services according to the UCP regulations. The following services would be considered medically necessary Eligible Services by the UCP.

- Contraceptives may be considered medically necessary if pregnancy would exacerbate an existing medical condition. Contraceptives may also be covered if they are needed to treat a medically necessary condition (i.e. some contraceptives have secondary uses which may be unrelated to pregnancy prevention, but may help treat another medically necessary condition).
- Abortions may be considered medically necessary if carrying the pregnancy to term would endanger the life or health of the mother.
- Fertility services may not be billed to the UCP.

All providers are subject to audit and should keep documentation in each patient's file to demonstrate medical need.

Family planning services for low-income men, women, and children may be available in your community. Providers or patients can contact the Massachusetts Department of Public Health Family Planning Program at 617-624-6060 or toll-free at 877-414-4447 for more information.

3.3.2 Visiting Nurse Association (VNA) Services:

VNA services are not Eligible Services per regulation 114.6 CMR 12.00, which specifically excludes home health services; therefore VNA services may not be billed to the UCP.

3.4 Medical Hardship

3.4.1 Eligible Medical Expenses:

The regulation stipulates that eligible medical bills for Medical Hardships are Allowable Medical Expenses. These expenses are not limited to Eligible Services, and may include bills for physician visits, tests, surgeries, etc. that are not necessarily eligible for UCP reimbursement.

3.5 Other

3.5.1 MassHealth Members with No Dental Coverage:

Providers may bill the UCP for medically necessary dental services provided to MassHealth members if those services are not covered by MassHealth.

3.5.2 Billing the UCP for EMTALA Level Screening in a Hospital ER Even When the Screening Determines that the Patient Does Not Need Emergency Level Services:

Emergency level screening is medically necessary and is an Eligible Service which may be billed to the UCP provided that the patient has been determined to be a Low Income Patient. If the patient is not determined to be a Low Income Patient, providers must follow the appropriate ERBD collection requirements prior to submitting the claim for screening to the UCP.

3.5.3 A Full UCP patient receives a prescription at an affiliated HLHC, but the HLHC does not have a pharmacy. The patient subsequently goes to the hospital to fill the prescription: May that prescription be billed to the UCP?

Yes.

4. REVS QUESTIONS

NEW

4.1 Basics

4.1.1 REVS Checks:

Low Income Patient status can be checked using REVS after 10/1/2004 if the patient has applied through the MassHealth application process. REVS will always show the richest aid category for an individual. If a patient is eligible for MassHealth then a MassHealth message will be visible; if the patient is not eligible for MassHealth but is determined to be a Low Income Patient, then a UCP message will be visible. It is assumed that the provider can bill the pool for services not covered by MassHealth or any other insurance or program.

4.1.2 REVS and UCP Statewide Determinations:

All eligibility determinations completed through MA-21 after 10/1/04 will be considered state-wide determinations and will not be facility-specific. Low Income Patient and MassHealth determinations will be accessible through REVS and participating providers throughout the state will be able to verify patient status through REVS.

REVS will always show the richest aid category for an individual. If a patient is eligible for MassHealth then a MassHealth message will be visible; if the patient is not eligible for MassHealth but is determined to be a Low Income Patient, then a UCP message will be visible. Once a patient is determined eligible for MassHealth, providers can bill the Pool services not covered by MassHealth, other insurance, or another program without any additional determinations or applications.

UCP determinations through the “old” Free Care application process will continue to be facility-specific. These UCP determinations will not be accessible through REVS.

4.1.3 REVS and the Virtual Gateway:

All determinations made through the Virtual Gateway or with the paper MBR are valid “state-wide.” These Low Income Patient determinations are not facility-specific. Any provider, even if they are not yet connected to the Virtual Gateway, can use REVS to check patient status.

4.2 REVS Eligibility and Other Programs

EAEDC: EAEDC provides coverage for emergency physician services at a hospital, all services provided by a CHC, and certain other services. Those medically necessary services not covered by MassHealth for this population may be billed to the UCP. Providers must make every reasonable effort to have EAEDC patients enroll in MassHealth and document all such efforts. Most EAEDC patients are eligible for MassHealth Basic and may enroll in MassHealth without

submitting an MBR / Virtual Gateway common intake application. These patients should be instructed to call the Health Benefits Advisor at 800-841-2900 to enroll.

Healthy Start: Providers must check REVS to determine patient status. Individuals approved for Healthy Start after July 1, 2004 will be listed on REVS under the coverage type: LMTD HLTHY STRT. Eligible women approved for Healthy Start before July 1, 2004 will not have their Healthy Start eligibility listed in REVS. If REVS shows LMTD HLTHY STRT, providers may bill the UCP for Eligible Services provided that they are **not covered by either MassHealth Limited or MassHealth Healthy Start.**

CenterCare: CenterCare enrollees use a CHC as their primary care provider. Since CenterCare is not a MassHealth program they will not be listed on REVS. To determine if the patient is a Low Income Patient, the provider must complete the MassHealth application process with the patient.

CMSP: Providers must check REVS to determine patient status. Individuals approved for CMSP after July 1, 2004 will be listed in REVS under one of two coverage types: CMSP, or LMTD CMSP. Providers may bill the UCP for services not covered by any other insurance or program for individuals with MassHealth Limited and CMSP who are also Low Income Patients. For those with only CMSP coverage type, the provider must check the patient's CMSP card to determine whether the provider may bill the pool for services provided to the patient not covered by the patient's other insurance or benefits. These cards show the patient's FPL; only providers whose patients are under 400% FPL may receive UCP payment for services not covered by other insurance or programs. If a patient is at 400% FPL or greater, REVs will display a message showing the UCP may not be billed. However, if an applicant is between 200-400% of FPL, the applicant may receive Partial Low Income Patient status. If the family income can be determined, the provider must calculate the deductible using the formula shown at Sec. 1.7.4 of this document: otherwise they may calculate a deductible as though the family has an income equal to 201% FPL.

MassHealth Premium Assistance: There are many different types of MassHealth premium assistance coverage types. Different coverage types will have different REVS messages. Some premium assistance types will have no message on REVS; this occurs when the patient has private insurance *only* for which MassHealth subsidizes the premium. These patients do not have any MassHealth benefits; therefore they do not show up on REVS. Other members with premium assistance have Standard coverage; these patients will show up on REVS with the Standard coverage type.

The UCP is always the payer of last resort. Accordingly, if a patient has premium assistance and MassHealth benefits, the UCP only provides payment for those UCP Eligible Services which are not covered by MassHealth, insurance, or other benefits.

Other Non-MassHealth Eligibility and UCP Wrap-around: Low Income Patient status is not implied by a patient's eligibility in other, non-MassHealth programs. REVS contains patient eligibility information about several other programs besides MassHealth, such as Senior Care

Options, DMH programs, and pharmacy programs. For example, a patient in the REVS system with the restrictive message of “Mental Health Services Only” is in REVS due to eligibility in a DMH (Department of Mental Health) program and does not have MassHealth eligibility and does not imply that the UCP can be billed for services not covered by other insurance or programs.

To determine eligibility for MassHealth / Low Income Patient status, the patient would have to complete a Virtual Gateway application or an electronic UCP application (if not on the Virtual Gateway yet).

4.3 Different Determinations between Providers and REVS

4.3.1 Different Partial UCP Deductible Determinations:

During this transition period, the Division will allow some provider discretion in the matter of Partial UCP deductibles. If a provider has a Low Income Patient with a deductible, but REVS indicates a different deductible amount, the provider may choose to apply the lower deductible.

For example, if a patient's deductible from the provider's UCP determination is lower than the one displayed by REVS, the provider can use that UCP determination until the patient's one year of eligibility expires. The opposite situation may also occur, in which the deductible calculated by the provider is actually higher than the one that shows up on REVS. Again, the provider has a choice of which deductible it wants to use - the one displayed by REVS or the higher deductible calculated by the provider.

4.3.2 UCP Determination on REVS and Different UCP Determination at Providers:

During this transition period the Division is allowing discretion in the matter of different UCP determinations. If a patient has Full UCP but is later found to have a Partial UCP determination in REVS, the provider can continue to treat that patient as a Full UCP patient until the expiration date of that patient's status. However, if that patient goes to another facility (where he does not have facility-specific Free Care eligibility), he will be treated as a Partial UCP patient as shown in REVS.

4.3.3 Different UCP Determinations in REVS (Ex. Full UCP for one date of service, Partial UCP for another):

Providers should use the most recent determination shown on REVS to determine the patient's status. If a patient goes from Partial UCP to Full UCP, the provider may bill the UCP for any unpaid bills for eligible services up to the deductible amount.

4.4 Using REVS as Documentation

4.4.1 REVS and billing the UCP for Services not Covered by MassHealth, Insurance or Programs (Wrap-around):

To receive payment for services not covered by MassHealth, the division recommends that the provider keep a REVS print-out documenting MassHealth eligibility. No condensed application is necessary to bill the UCP in this case.

4.4.2 Pending UCP Application—REVS as Documentation for Income and Residence:

If an application at a specific facility is awaiting documentation from the patient, but the patient's Low Income Patient status then becomes visible in REVS, the REVS message cannot be used as "documentation" for that pending application. The REVS print-out does not provide sufficient information about the applicant's residence and income to qualify as documentation.

Until the patient completes the pending application, the determination shown in REVS should be used as the valid determination. If the patient completes the pending facility-specific application (with the correct documentation), the provider may use that determination, or the REVS determination, for billing purposes. Once a provider is transitioned completely onto the Virtual Gateway, the MassHealth process will be the only eligibility determination system for Low Income Patient status/ MassHealth.

4.4.3 “ZZ” numbers in REVS:

The ZZ number is a member ID that is generated when an individual does not have a social security number (SSN).

If a patient does not have an SSN, then a REVS check using name and DOB will result in a response that does not include a field for SSN. The response will include the field “Member ID” for the ZZ number.

4.5 REVS and Difficulty Determining Federal Poverty Level

4.5.1 CHC Sliding Scale Payments and Inability to Determine FPL:

If a Low Income Patient is determined to be a Partial-UCP patient but their specific income cannot be determined, they are to be assessed a fee on the CHC sliding scale as though their income were 201% FPL.

4.5.2 UCP Wrap-around Deductibles for CMSP patients between 201 - 400% FPL:

Since REVS does not display the income of CMSP patients, and a CMSP card only reflects income ranges, patients whose income is determined to be between 201-400% FPL will all be assessed a deductible amount as if they had an income level equal to 201% FPL. Those CMSP

patients seeking services at a CHC will be assessed a sliding scale fee as though their income were equal to 201% FPL. Providers should always check all members of the family in REVS to see if a family deductible amount is present. If a family deductible can be ascertained using REVS, it should be used. Providers may also ask if the patient has their MassHealth determination letter which will reflect their deductible amount. The specific deductible amounts for 2005 are reflected below. Income levels are reflected on a CMSP card as follows:

- 01: <200% FPL
- 02: 200-400% FPL
- 03: 400< % FPL

Family Size		200%	201%	Deductible
1		\$19,140	\$19,236	\$38.28
2		\$25,660	\$25,788	\$51.32
3		\$32,180	\$32,341	\$64.36
4		\$38,700	\$38,894	\$77.40
5		\$45,220	\$45,446	\$90.44
6		\$51,740	\$51,999	\$103.48
7		\$58,260	\$58,551	\$116.52
8		\$64,780	\$65,104	\$129.56

5. BILLING QUESTIONS

NEW

MassHealth / Medicare Estate Recovery

While MassHealth regulations allow the State to recoup certain health care costs after a patient's death, UCP regulations do not allow such action to be taken. When a person applies for coverage through a MassHealth application, the UCP does not have any right to recoup costs as MassHealth does.

5.1 MassHealth Related

5.1.1 Billing the UCP for Services Not Covered by MassHealth:

When a patient is enrolled in MassHealth, providers can bill the UCP for Eligible Services that are not covered by MassHealth without any additional determinations or applications. A condensed application is not necessary.

As of 10/1/04, payment by the UCP for services rendered to patients not covered by MassHealth, other insurance, or programs is as follows:

- MassHealth co-pays with dates of service on or after 10/1/04 may no longer be billed to the UCP
- MassHealth deductibles with dates of service on or after 10/1/04 may no longer be billed to the UCP
- Services not covered by MassHealth, but that are UCP Eligible Services, may be billed to the UCP.

5.1.2 Billing UCP during DDU Pending Period:

For allowable UCP claims during a Disability Determination Unit (DDU) pending period, providers have two options: Claims for Eligible Services may be written off to the UCP and later voided if MassHealth approves the disability. Alternatively, the provider may wait until MassHealth eligibility is determined before billing the claims to MassHealth or the UCP if the patient's disability is denied.

The UCP is always the payer of last resort; if the patient is later found to be eligible for MassHealth, the provider is required to void any claims made to the Pool and bill those claims to MassHealth.

5.1.3 Billing Low Income Patients who have a MassHealth CommonHealth Deductible:

A patient who is determined a Low Income Patient because s/he has yet to meet a CommonHealth deductible can choose to be billed for services that would normally be billed to

the UCP to acquire bills toward their deductible. Patients should not be prevented from acquiring bills toward a MassHealth deductible because of their Low Income Patient status.

Such patients with potential CommonHealth eligibility will show up in REVS with Low Income Patient status, but if the patient tells the provider that s/he is trying to meet a CommonHealth deductible, the hospital or CHC is allowed to bill the patient for the MassHealth deductible. Regulation 114.6 CMR 12.08(3) allows providers to bill patients for MassHealth deductibles. The provider should note in the patient's file that the patient has asked to be billed for the purposes of meeting a MassHealth deductible.

The Division is working on expanding information in REVS to allow providers to see when a MassHealth CommonHealth deductible has been assessed.

5.1.4 MassHealth PCCs and Billing the Pool for other Non-Covered Services

Providers may not submit claims to the UCP for MassHealth members who receive services at a PCC that is not their designated PCC.

5.2 UCP Deductible

5.2.1 Proof of Meeting Partial UCP Deductible:

Without proof that an individual has met his/her Partial UCP deductible, claims for services cannot be written off to the Uncompensated Care Pool. Providers are responsible for tracking bills if a patient has no other family members and uses only one facility. Patients are responsible for tracking their own bills if more than one member of the family is using UCP services, or if patients are using more than one medical facility to receive their care. Providers can assist patients by contacting other hospitals and/or CHCs to try to get documentation of a met deductible.

5.2.2 Using Prior Medical Bills to Meet UCP Deductible:

Patients can apply prior paid medical bills to their UCP deductible if those services meet the criteria of Eligible Services, and were provided to the patient (evidenced by date of service) during the period during which they are determined to be Low Income Patients. The eligibility period for patients determined to be Low Income Patients on or after 10/1/04 is from 6 months prior to the date of determination through one year after the date of determination. For patients with determinations completed before 10/1/04, the eligibility period includes one year prior to the date of application.

Bills incurred before the eligibility period are not eligible for use against the Partial UCP deductible.

5.2.3 Partial UCP Deductible and Community Health Centers:

When a Partial UCP patient receives services at a Community Health Center (CHC), the CHC uses the patient's income information to calculate, on a sliding fee scale basis, the percentage of the fee for which the patient is responsible. Once that percentage has been established, the patient is responsible for that percentage of the fee every time s/he receives CHC services until such time as s/he meets the deductible amount. The CHC may bill the remainder of the CHC fee to the UCP.

5.2.4 Relationship between MassHealth Spend-downs and Partial UCP Deductibles:

Both the MassHealth spend-down and the Partial UCP deductible have medically necessary criteria. However, medically necessary MassHealth spend-down services can cover a much broader scope while only medically necessary CHC and acute hospital services meet the UCP deductible.

For example, while UCP patients can use bills from CHC dentists to meet the deductible, they cannot use bills from private dentists to meet their deductibles. A MassHealth spend-down patient can use a bill from a private dentist or physician or pharmacy or optometrist to meet the spend-down.

If a patient must meet both a MassHealth spend down/deductible and an UCP deductible the patient may use the same expenses towards meeting both deductibles -- as long as the expenses used to count towards the UCP deductible were for medically necessary services as defined under 114.6 CMR 12.00. If the MassHealth deductible was never met, then the Partial UCP deductible applies and must be fulfilled.

NOTE: A Low Income Patient CAN use these bills to meet the Medical Hardship contribution.

5.3 Retroactive Billing Period

5.3.1 Billing Period:

Prior policy allowed providers to bill within one year of the date of service or determination date, whichever was later. The current regulation allows providers to bill to the UCP for services rendered up to 6 months prior to the date of application. Services billed to the Pool after the end of the patient's eligibility period (due to billing cycle delays) are allowable as long as the service date falls within the patient's eligibility period.

5.3.2 Effective Date of 6-Month Retroactive Billing Period:

All Eligible Services for patients applying on or after 10/1/04 are subject to the new 6 month retroactive billing period regardless of which application tool the provider is using.

5.3.3 Retroactive Period and ER Bad Debt:

The retroactivity policy covers only claims for people who have applied for UCP on or after 10/1/04. It does not cover any ERBD claims. ERBD claims have no time limitation; however, providers must show continuous collection activity for all ERBD claims.

5.4 Residency Requirements

5.4.1 Non-residents:

As of 10/1/04, non-residents cannot be determined Low Income Patients. However, a provider may bill the UCP for services provided to non-residents currently determined Low Income Patients (determined prior to 10/1/04), but only at the facility from which they applied. Eligible Services provided at another facility may not be billed to the UCP.

5.4.2 Residency Requirement and Billing ER Bad Debt:

Providers are required to check REVS prior to writing off ERBD claims to the Pool in order to ensure that the patient does not have MassHealth or UCP. The requirement is designed to prevent ERBD claims that could be covered by another payer. While out-of-state residents will not show up in REVS, the regulations still require a REVS check.

5.5 Billing Low Income Patients

5.5.1 Billing Low Income Patients for Non-Eligible Services:

Regulations prohibit providers from billing Low Income Patients (114.6 CMR 12.08 (3)) with the exception of co-pays and deductibles required under MassHealth; Partial UCP; UCP Pharmacy Co-pays; Emergency Aid to the Elderly, the Disabled and Children program (EAEDC); the Healthy Start program; or the CenterCare program. Non-UCP Eligible Services that are still provided to these patients cannot be billed to patients.

5.5.2 Billing Low Income Patients for Services Provided Before the UCP Eligibility Period:

Regulations prohibit UCP providers from billing Low Income Patients (114.6 CMR 12.08 (3)). Even services provided before the eligibility period—such as services provided before the 6 month retroactivity period—cannot be billed to Low Income Patients.

5.5.3 MassHealth / Medicare Estate Recovery

While MassHealth regulations allow the State to recoup certain health care costs after a patient's death, UCP regulations do not allow such action to be taken. When a person applies for coverage through a MassHealth application, the UCP does not have any right to recoup costs as MassHealth does.

5.6 CHCs and Prescriptions (340B, Pharmacy Co-pays, etc.)

5.6.1 340B Pharmacies and Billing the Pool for Drugs not on the MassHealth Drug List:

If a CHC 340B pharmacy wishes to dispense a drug that is not on the MassHealth approved drug list, they may do so if that drug has been approved by the CHC's internal P&T committee provided that the drug is not on the MassHealth excluded drug list. This could include drugs that are preferred for documented clinical reasons as well those that can be obtained more inexpensively than a generic equivalent due to 340B pricing

5.6.2 Billing the Pool for Pharmacy Dispensing Fees for Medications Provided to Pool Patients Using a Free Pharmaceuticals Program:

CHC 340B pharmacies may bill the dispensing fee only for prescriptions provided to Low Income Patients to the Pool even if that individual is using a pharmaceutical company sponsored free drug program (e.g., Share the Care) as long as the drug is dispensed through the center's pharmacy. Providers may not bill the Pool for free or donated prescribed drugs where the drugs are stored and handed out from a site other than the pharmacy (e.g., secured closet near exam rooms).

5.6.3 Registering a CHC's 340B Pharmacy status with the UCP:

Before a CHC can bill the UCP for prescribed drugs provided through its pharmacy, the center must email their 340B ID number, and the date upon which the CHC plans to begin billing the UCP. This information should be sent ***no more than*** 3 months before the date billing commences. Please send the registrations to Rosa Alvarado at the Division of Healthcare Finance and Policy at rosa.alvarado@state.ma.us.

5.6.4 CHC and Pharmacy Co-pays

CHCs may collect a co-pay to cover reasonable remaining pharmacy costs, but are given the flexibility to create their own co-pay structure. However, the cumulative revenue from all patient co-pays is not to exceed 25% of the aggregate Actual Acquisition Cost (AAC) of the drugs and unreimbursed reasonable dispensing costs exceeding the \$7.50 dispensing fee.

5.6.5 Pharmacy Co-pays and Partial UCP deductibles:

Pharmacy co-pays cannot be counted towards a partial deductible. However, any additional amount owed by the patient based on the sliding scale cost of the prescription may be counted toward the patient's deductible.

5.6.6 UCP payments to CHCs for Prescriptions; Partial & Full UCP patients:

Full

The UCP will pay CHCs 75% of the Actual Acquisition Cost (AAC) of the drug + a \$7.50 dispensing fee.

The patient may be required to pay a co-pay set by the CHC as per 114.6 CMR 11.08(3)(a)(3)(b).

Partial

The UCP will pay CHC's the portion of the 75% AAC and \$7.50 dispensing fee not covered by the patient's sliding scale CHC contribution. For example if a patient is required to contribute 20% of the bill, the CHC will be reimbursed: **80%(75% AAC + \$7.50)**.

If a CHC assesses pharmacy co-pays pursuant to 114.6 CMR 11.08(3)(a)(3)(b) (see above), those pharmacy co-pays do not count towards a patient's partial UCP deductible. However, the patient's sliding scale contribution for the prescription – e.g. 20 % (75% AAC + 7.50) – counts toward the patient's partial UCP deductible.

See also: **2.8.3**

5.7 Other

5.7.1 Family Planning or Contraceptive Services:

Family planning services are only billable to the UCP if they are medically necessary, Eligible Services according to the UCP regulations. The following services would be considered medically necessary Eligible Services by the pool:

- Contraceptives may be considered medically necessary if pregnancy would exacerbate an existing medical condition. Contraceptives may also be covered if they are needed to treat a medically necessary condition (i.e., some contraceptives have secondary uses which may be unrelated to pregnancy prevention, but may help treat another medically necessary condition).
- Abortions may be considered medically necessary if carrying the pregnancy to term would endanger the life or health of the mother.
- Fertility services may not be billed to the UCP.

All providers are subject to audit and should keep documentation in each patient's file to demonstrate medical need.

Family planning services for low-income men, women, and children may be available in your community. Providers or patients can contact the Massachusetts Department of Public Health Family Planning Program at 617-624-6060 or toll-free at 877-414-4447 for more information.

5.7.2 Addendum to Credit and Collection Policy:

Providers may submit an addendum to their credit and collection policy as long as the addendum is in compliance with the new regulation. Providers have 90 days after the adoption of amendments to the Credit and Collection regulation 114.6 CMR 12.08(1)(c) that would require a change in the Credit and Collection Policy to submit their credit and collection policies to the Division.

5.7.3 Deposits:

The policies on deposits and payment plans have not been changed. Deposits are allowed for Partial UCP and Medical Hardships. Per regulation 144.6 CMR 12.08 (1)(f), deposits for Partial UCP patients must be limited to 20% of the deductible, up to \$500; deposits for Medical Hardship patients must be limited to 20% of the medical hardship contribution, up to \$1,000.